wcb Workers' Compensation Board – Alberta

P.O. BOX 2415
EDMONTON, AB T5J 2S5
FAX: 780-427-5863
1-800-661-1993

C534
PT Comprehensive Progress/Discharge Report

WORKER DETAILS

Surname	First Name and Initial	Legal Gender ☐ Male ☐ Female	WCB Claim Number
			Date of Birth (yyyy/mm/dd)
Address Street	City/Town	Province / Postal Code	Telephone Number

Worker's Job Title/Occupation:	Progressive Injury? ☐ Yes ☐ No	Date of Injury (yyyy/mm/dd)

Describe how and when the injury/condition occurred.

Examination
Symptoms:

Objective Findings:

Change in Diagnosis? If yes, describe

☐ Yes ☐ No

Diagnostic Code 1:	Diagnostic Code 2:	Diagnostic Code 3:

Part of body:	Side of body:	Nature of Injury:

Affected Movements Patterns

Type	ROM Left (degrees)	ROM Right (degrees)	Strength

Pain Scale:	Type of Pain:

Neurological Exam Normal? ☐ Yes ☐ No If no, describe

Gait changes? ☐ Yes ☐ No If yes, describe

Any other findings (Including functional status)?

Are you aware of any prior conditions in the same anatomical area? ☐ Yes ☐ No

If yes, please provide diagnosis and treatment(s) for prior condition:

Treatment Plan

Treatment Plan

Weeks since PT assessment?

How are physiotherapy services being provided? ☐ In-person ☐ Virtual ☐ Hybrid

What interventions are you employing?

- ☐ Acupuncture/IMS/needling
- ☐ Education
- ☐ Electromodalities
- ☐ Joint mobilization
- ☐ Joint manipulations
- ☐ McKenzie technique
- ☐ Soft tissue techniques
- ☐ Taping/Bracing
- ☐ Traction
- ☐ In clinic cardiovascular activity
- ☐ In clinic strengthening
- ☐ In clinic stretching
- ☐ In clinic work conditioning
- ☐ Other (GMI, ect.)

Patient engagement to therapy

Recovery or return to work barriers? ☐ Yes ☐ No

- ☐ Hesitancy to return to work
- ☐ Not Job attached or lack of appropriate modified work
- ☐ Reported employee/employer issues
- ☐ Pain/impairment barriers beyond expectation for injury
- ☐ High perceived disability
- ☐ Fear of movement of activity
- ☐ Patient appears anxious or depressed
- ☐ Severe injuries with likely long term or permanent work restrictions
- ☐ Other (i.e non-compensable conditions) Explain:

Recommendations

- ☐ Case conference with WCB claim Owner or WCB PT Consultant *(Specify)* _____
- ☐ Request additional documents _____
- ☐ Additional services in conjunction with community physiotherapy? _____
- ☐ Further medical investigations _____
- ☐ Return to work services _____
- ☐ Other, describe:

Has the patient received a home exercise program: ☐ Yes ☐ No

Describe:

Treatment at your clinic complete? ☐ Yes ☐ No

Is this a request for treatment extension beyond the current authorized time frame? ☐ Yes ☐ No

Estimated discharge date from community physiotherapy: (yyyy/mm/dd)

Is the patient progressing in work abilities? ☐ Yes ☐ No ☐ Not applicable

Do you anticipate a successful return to work outcome within the next 3 weeks? ☐ Yes ☐ No ☐ Not applicable

Explain:

Has the patient missed work beyond the date of accident? ☐ Yes ☐ No

Has the patient returned to work? ☐ Yes ☐ No If yes, Date Returned *(yyyy/mm/dd)*

Job Requirements?

If the patient is currently not working, can the patient return to work? ☐ Yes ☐ No

Complete the following. Please make a selection below as they relate to the injury:

Sitting	☐ Able	☐ Unable	☐ Limited to____Hours
Standing	☐ Able	☐ Unable	☐ Limited to____Hours
Walking	☐ Able	☐ Unable	☐ Limited to____Hours
Bending	☐ Able	☐ Unable	☐ Limited
Twisting	☐ Able	☐ Unable	☐ Limited
Kneeling/squatting	☐ Able	☐ Unable	☐ Limited
Climbing	☐ Able	☐ Unable	☐ Limited
Lifting	☐ Able	☐ Unable	☐ Limited, Max of____ (lbs/kg)
Pushing/pulling	☐ Able	☐ Unable	☐ Limited
Overhead reaching	☐ Able	☐ Unable	☐ Limited
Driving	☐ Able	☐ Unable	☐ Limited to____Hours

Other restrictions or additional comments/special considerations:

If not currently able to work, estimated return to modified work *(yyyy/mm/dd)*

Estimated return pre-accident work *(yyyy/mm/dd)*

Or ☐ Long-term temporary restrictions (>12 weeks) ☐ Permanent restrictions anticipated ☐ Unknown

What accommodations/modifications would support sustainable return to work?

☐ Workstation analysis ☐ Modified hours ☐ Modified duties ☐ Gradual return to work ☐ Other, describe:

Recommendations for a gradual return to work plan:

Patient is in agreement with return-to-work details? ☐ Yes ☐ No If no, explain:

Name and address to whom fee is payable: (Please print)	Signature	Physiotherapist Printed Name
	Telephone Number	Fax Number
WCB Billing Number:	Clinic Email Address	Report Date *(yyyy/mm/dd)*

If you are a physiotherapy provider in Alberta and do not have a contract with WCB Alberta, please contact WCB Healthcare Strategy at hcs.physiotherapy@wcb.ab.ca to discuss provision of services.